STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145433	A. BUILDING _____ B. WING _____	08/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE PINE VIEW CARE CENTER	611 ALLEN LANE ST CHARLES, IL 60174

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F 514	Continued From page 19 6/14/12 and 6/18/12, respectively. R12 has 7 daily treatments ordered, including daily skin checks, daily safety alarm checks, daily gastrostomy care and application of daily skin treatments, according to the 6/1 - 6/30/12 TAR. The TAR reflects that treatments were provided to R12 between 6/14 - 6/18/12, even though R12 was in the hospital on these days. On 8/29/12 at 4:00 PM, Z2 (Physician) said that the documentation that treatment was done on R12 when R12 was not at the facility is "a problem." On 8/29/12 at 4:05 PM, E2 (Director of Nursing) said that she does not know why the TAR was completed on the days that R12 was in the hospital, but was going to find out.	F 514		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.1220b)3) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each	F9999		

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F9999	Continued From page 20 resident to meet the total nursing and personal care needs of the resident. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) THESE REQUIREMENTS WERE NOT MET AS EVIDENCED BY: A. Based on observation, interview and record review, the facility failed to provide supervision and follow the fall policy to update care plan to prevent further falls. This applies to 1 of 6 residents (R9) reviewed for falls in the sample of 18.	F9999		

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R9 was sent to the hospital on 01/16/12 due to a fall and which resulted in R9 sustaining a left hip fracture.

Findings include:

R9 was admitted to the facility on 05/25/11 with diagnoses of Hemiplegia, Diabetes Mellitus, Hypertension and Chronic Airway Obstruction. R9 had left side weakness due to her diagnosis.

Review of incident reports documented that R9 had the following falls on the following dates:
1. On 12/15/11 at 3:30 PM: CNA (Certified Nursing Assistant) reported to the nurse resident on floor -- upon entering room -- found on floor alert oriented X 3 -- ROM (Range of Motion) good to right upper and lower extremities -- left sided paresis -- denies pain.

2. On 12/16/11 at 8:00 PM: Resident found on bathroom floor calling for help at 2000 (8:00 PM). Left elbow bleeding. Resident states she slightly hit her head on the wall. She indicated that she was trying to get off her wheelchair onto the toilet and fell.

3. On 12/28/11 at 11:21 AM: Nurse entered room the resident's and she was on the floor sitting up right next to bed with legs extended. Resident undid alarms she stated. Denies hitting her head. No change in LOC (level of consciousness). CNA and nurse used mechanical lift and put in w/c (wheel chair). Clip alarm intact.

4. On 01/16/12 at 6:15 PM: Resident found on floor in bathroom laying on left side with head

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F9999	Continued From page 22	F9999		

against wall. Alarms were sounding. Stated she slightly hit her head. No change in LOC. Unable to move her left leg without pain. Swelling noted near hip.

R9 was sent to hospital and this incident resulted with a left hip fracture.

Preventive recommendation included.
"Resident educated on not going to the bathroom or self transferring without assistance. Resident educated on use of a call light. Sensor alarm and floor mat alarm supplied to resident due to decreased safety awareness. Clip alarm remains in effect. Staff educated to toilet resident prior to meal and immediately after meals. Staff educated to provide 15 minutes checks due to decreased safety awareness."

5. On 03/26/12 8:10 PM: Resident found on Left side and Left arm near her roommates bed. Alarm was sounding. Resident c/o (complained of) left arm pain at wrist and left elbow. Noted purple discoloration on left wrist. Also L (left) knee and R (right) toe abrasion.

No other preventive measures were implemented. The alarms have not prevented any fall episodes.

6. On 05/18/12 6:45 PM: CNA heard an alarm at 6:45 PM, CNA responded and observed Resident sitting in front of the toilet. Resident stated she got up by herself and fell and hit left arm to the trash can. Sustained small discoloration to her left arm and 2 small hematomas.

No intervention added.

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F9999	Continued From page 23 7. On 05/20/12 1:10 PM: CNA heard an alarm and again observed resident on the floor face down. Resident stated that she got up from the toilet and was trying to wash her hands at the sink and lost her balance. Abrasion to right elbow noted. Cleanse with wound cleanser and covered with steri strips. No intervention added. 8. On 05/22/12 11:00 AM: Informed by CNA-- assisted to floor after leg giving away-- Alert oriented x 3. C/O (complained of) pain to left hip region-- No redness no swelling. Skin tear on her right forearm. Per facility's investigation: This fall occurred while resident was standing being transferred by staff to toilet. Resident fell while staff was lowering resident's (R9) pants. Facility did not assess whether gait belt was in use. The incident report recommended the use of mechanical lift transfer. 9. On 06/25/12 at 9:25 AM: Slipped in BR (bathroom) while being assisted from toilet to wheelchair, struck left temple on towel bar. No intervention added. On 08/28/12 at 8:45 AM, R9 was observed propelling her wheel chair in her room to the bathroom. E 17 (CNA) transferred R9 to the toilet without using gait belt. E17 was observed with gait belt on her (E17) waist. E17 was asked why she did not use the gait belt while transferring R9. E17 said that R9 was in a hurry to use the	F9999		

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F9999	Continued From page 24 bathroom. On 08/28/12 at 1:30 PM, R9 was observed in bed with call light not within reach. E11 (Nurse) was informed and found the call light was under the bed. On 08/29/12 at 3:00 PM, R9 was observed up in wheel chair. E22 (Hair Dresser) was pushing R9 with no foot rest and both feet were dangling. E11 was informed and told E22. It was also observed that R9 did not have the non skid pad on the wheel chair. E21 (CNA) was also interviewed on 08/29/12 at 1:00 PM regarding the incident dated 06/25/12. E21 stated, "I was assisting R9 from toilet to wheel chair and R9 bumped her head on the towel bar and then slipped in the bathroom. E21 was asked if she was aware how many assist does R9 needed to transfer. E21 stated, "I thought 1 assist." E21 was asked again how would she know if R9 needed 1 assist. E21 said that there is a care plan behind R9's closet door. Resident care plan behind R9's closet door documented to transfer R9 with 1- 2 assist with gait belt and with quad cane. Apply anti skid pad. Care plan intervention included: - Keep equipment within reach (call bell, phone). - Encourage resident to ask for assistance with transfer. - Continue to monitor risk factor. - Orient resident to environment and how to call for assistance. The above care plan was not followed.	F9999		

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F9999	Continued From page 25 E11 stated on 08/29/12 at 3:00 PM, "the staff are aware that R9 is high risk for falls. R9 uses one arm to propel her wheel chair and the other arm had stroke." E11 stated that R9 is confused at times and probably when you asked R9 the date, R9 won't know." Minimum Data Set Assessments (MDS) dated 7/21/12 showed R9 was dependent on staff for bed mobility, transfer and toilet use. R9 has poor safety awareness due to moderate cognitive impairment. MDS dated 09/20/11, 12/20/11 and 4/27/12 documented that R9 needed extensive assistance with 2 persons physical assist. Review of nurses notes dated 12/29/11, 1/24/12, 3/31/12, 4/09/12 and 5/21/12 documented that R9 is alert with confusion, forgetful and with poor safety awareness. (B)	F9999		